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AUTHOR Drotar, Dennis
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ABSTRACT

The experience of consultants in a pediatric hospital indicates that infant failure to thrive is almost always associated with strain in the relationships of the infant's caregivers. Consequently, a nontraditional, long-term, home-based, and family-centered model of evaluation and treatment of failure to thrive has been developed which involves family members in assessing how family influences disrupt nurturance and which engages family members in ongoing therapeutic work. Intervention is directed toward containment of family relationship problems, employment of more adaptive stress management, and restructuring of the child's nurturing context. To assess the effectiveness of the family-centered intervention, comparisons are being made between outcomes of two alternate approaches to intervention: a parent-centered approach focusing on the major caretaker and an advocacy approach involving short-term support and indirect treatment. Infants are assessed at six-month intervals on intellectual development, play behavior, attachment, and language competence. Additionally, monthly home observations are being made of parent-child interaction. Preliminary follow-up data for small samples of predominantly low-income families with infants at 1 year of age reveal improved weight gain, maintenance of intellectual abilities, and, in comparison to prior studies, more positive attachment behavior. Analyses of data now being collected are expected to show that the family-centered approach to intervention results in longer lasting gains in infants' developmental and psychosocial competence. (Author/RH)

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FAMILY CENTERED INTERVENTION WITH INFANT FAILURE TO THRIVE

Dennis Drotar, Ph.D.

Case Western Reserve University

School of Medicine

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Although it has long been recognized that failure to thrive is associated with a high level of intrafamilial stress, the way in which the family context influences the development and outcome of this common pediatric problem has not been adequately described nor have treatment approaches addressed family influences. Our experiences as consultants in a pediatric hospital and retrospective chart review (Drotar, Malone, Negray & Dennstedt, 1981; Drotar & Malone, in press) indicate that family members are rarely involved in hospital based psychosocial treatment planning or intervention following pediatric hospitalization. Because the interpersonal context that has generated the infants' difficulties is usually not addressed in treatment, the nutritional and developmental gains made by failure to thrive infants during hospitalization are not always sustained in their home settings, judging from available long term outcome data which documents a high incidence of learning, behavior, and relationship problems in school-aged children who present with failure to thrive as infants (Hufton & Oates, 1977; Drotar, Malone & Negray, 1979).

To better understand the family relationships of failure to thrive infants, we have now engaged in assessment and intervention with over fifty failure to thrive infants in both hospital and home settings over the past five years. Although we have found striking variations in family constellations and structure our experience strongly indicates that the infant's failure to thrive almost always signals a family relationship strain, ranging from severe conflict to emotional isolation, among the infant's parenting partners, that is between the infants' mother and a person of primary significance to her, e.g. boyfriend, father, mother, or other member of the extended family. In turn, these family relationship problems interact with a host of other factors, including parents' nurturing histories to disrupt their capacities to protect the infant's

nurturing from life stress. Ironically, as in other psychosomatic conditions, these severe relationship problems are often minimized, denied, or avoided by family members, and localized in the child, a defensive strategy which places the origins as well as avenues for positive change outside the sphere of family influence. By the time the failure to thrive infant is admitted to the hospital, the infant may be labeled as sick or small and be isolated from family caregivers, as poor nutrition and stimulation take their progressive toll. Clinically, one is struck with the contrast between the compelling nature of the child's nutritional deficits, and the parents' seeming obliviousness to the child's emotional needs and concern with the infants organic condition. We have learned to construe the apparent lack of emotional connection between mother and child which is often observed initially during the hospitalization, as a part of broader patterns of family disconnection. A in infants such as Jesse, a young infant whose parents rarely talk to one another. Jesse's mother feels unsupported and dominated by her husband. In many ways, the mother's relationship with Jesse mirrors the isolated interactions with her husband. She cannot talk to Jesse or read his signals.

In keeping with observations that the infant's failure to thrive is so often associated with family relationship difficulties, we have developed a family-centered model of evaluation and treatment of failure to thrive which involves family members in assessment of how family influences disrupt the child's nurturing and engages family members in ongoing therapeutic work directed toward containment of family relationship problems, more adaptive stress management, and restructuring of the child's nurturing context. This model of family centered care of failure to thrive represents a significant departence from traditional care patterns in a number of important ways. First, as soon as it seems clear that environmental factors are involved in the infant's difficulties, parents are given the clear message that family

stresses are related to the problem and that family members are necessary for the resolution of the problem. This initial message, which is coupled with active, persistent attempts to reach out to the parents, as well as empathic understanding of stresses which are caused by the infant's hospitalization, often helps counter the parents defensive appraisal of the infant as physically impaired and sets the stage for them join with us in intervention following hospitalization. However, as many who work with the families of failure to thrive infants will attest, the engagement phase of treatment can be the most difficult of all, as many parents struggle to retain their appraisal of the child as impaired in order to maintain their system intact. Moreover, severe reality problems, such as transportation, finances, and the demands of children at home, can contribute to the difficulty of engaging parents. Parents' anxieties can also be markedly intensified in the hospital mileu, where it is very difficult to arrange a positive treatment environment. Parents and their interactions with their infant are inevitably scrutinized through the staff's observation and history taking. Finally, as the infant begins to do well in the hospital, it is very easy for the parents to experience these gains as an insult because they were accomplished outside the sphere of family influence.

Our initial approach to parents involves a primary attention to their current concerns, worries, and frustrations. Since we know we will be working with the family for some time to come, we can afford to wait on gathering further information concerning how the problem began until the parents can tell or show us themselves. One of the most important principles we have learned in our work concerns the necessity for hospital based evaluation to be followed up with outreach treatment which continues over a period of time. The families of failure to thrive infants are often lost to follow up after the hospitalization, partly because there are so few infant mental health resources

in the community, and also owing to the difficulty of integrating hospital based resources with community fqcilities (Drotar & Malone, in press). Another innovative aspect of our approach is that the treatment is centered in the family home. We believe that this arduous method of treatment is justified on the basis of the seriousness and chronicity of the infant's problem, which is a definite threat to the child's long-term growth and development and because many disadvantaged, highly stressed families cannot manage participation in clinic based treatment. Our home based treatment visitation approach allows the opportunity for observations of family transaction which constitute the raw materials for intervention and provide an avenue for a unique understanding of the family structures and organization associated with failure to thrive. The flavor of this treatment is shown in the following clinical example taken from the pilot phase of our work.

> Like a number of children in our sample, Randy a two month old infant, and first presented to us in his second hospital admission for failure to thrive and is from a large extended kinship unit including his mother, widowed a year before, siblings ages 2, 4, 6, a great grandmother and father living next door along with two uncles, and Randy's aunt who often visited with her three children. During Randy's hospitalization, we caught a glimse of how the availability of so many adult caretakers turned out to be a major disadvantage for his nurturing in the sense that this pattern prevented his mother (or any adult caretaker for that matter) from making a specific attachment to him. We observed that whenever Randy fretted or fussed, he was immediately handed over to his aunts or to other family members. Meal times were highly confusing, disorganized, and filled with the stresses of Randy's siblings, each of whom clamored for their mother's attention like so many hungry birds. In structural terms, Randy was raised by the family group in a way that prevented the smooth reciprocal interaction and regulation of feeding and sleeping patterns characteristic of more adaptive early mother-infant dyads. Early on, one of our most salient early observations concerned how the entire family perceived Randy as a sick, vulnerable child who could only be cared for by the hospital. In fact, the families' panic ridden approach to Randy's care involved their taking him to the hospital with the exception

that he would be cured by the professionals, a scenario that was repeated a number of times. One important message that framed our early intervention with this family was that Randy was not physically vulnerable and could be cared for adaptively by the family but only if they worked with us to make changes. We searched for a way of organizing Randy's care and attachments and decided to restructure the nurturing context by reinforcing Randy's mother and grandmother as a major unit of collaboration and deemphasizing participation of Randy's aunt. We learned that Randy's mother and aunt, who had been sharing his care, had long been in conflict. As mother and grandmother became more of a unit, it was possible to construct a calmer more adaptive nurturing network. Meal times were reorganized to include two adults, mother and grandmother working in tandem. The grandmother was encouraged to take on the formidable task of feeding Randy's 18 month old sister who had a history of undiagnosed failure to thrive and was very demanding. Another longer-term goal was to centralize Randy's mother as his major caretaker, which proved to be quite difficult owing to her ambivalence and anxiety. However, slowly she began to relate more positively to him. As Randy began to want his mother and no one else, his great grandmother supported this by refusing to take him in times of stress and by comments such as "he loves you and no one else". Over the course of an 15 month period, important changes in the family system were reflected in Randy's increased weight gain, average cognitive development and secure attachment behavior.

We are now assessing the efficacy of a family centered intervention, compared to two alternative patterns, a parent-centered focused on the major caretaker, and an advocacy approach involving short term support and indirect treatment. The structuring of these interventions are shown in the following slide: (Insert slide 1) Our infants are followed at six month intervals in a comprehensive outcome assessment including intellectual development, play behavior, attachment, language competence, and with monthly home observations of parent-child interaction as shown on the following slide (Insert slide 2). Since we are only in our second year of the project, our numbers are as yet too small to provide any data broken down by treatment group. However, slide 3 shows descriptive data concerning thirty three families. Although family structures and size are variable, impoverished families are over represented. The next slide shows preliminary follow up outcome data

age age one year concerning physical growth on a small sample of 13. (Insert slide 4). Although the numbers are much too small to allow any firm conclusions, you will note improved weight gain from the onset of the study. The intellectual abilities of our high risk sample, as measured by the Bayley Scale, (Bayley, 1969) is shown on the next slide (slide 5) have been maintained. Another part of our battery involves attachment behavior as measured by the Sroufe-Waters adaptation of the Ainsworth separation reunion situation (Sroufe & Waters 1977) which is shown in the following slide (Slide 6). Although this finding is difficult to evaluate without a comparison group, this is a much more positive outcome concerning attachment behavior than prior studies of this population (Gordon and Jameson 1979).

Since our outcome assessment is still very much in the preliminary stages, firm conclusions concerning the effects of different intervention plans cannot be made. However, owing to the fact that a family centered approach includes multiple family members in treatment caretakers, each of whom can exert an important direct effect on the child, and indirectly as a support for the mother, we believe that the family oriented approach should result in longer lasting gains in developmental and psychosocial competence. Our work indicates that a home based family centered approach has unrecognized potential as a treatment modality for infant mental health problems which occur in disadvantaged, hard to reach families. Subsequent reports will provide a more detailed explication of this model of intervention and evaluation of this model through comprehensive study of outcome.

PSYC 20/P

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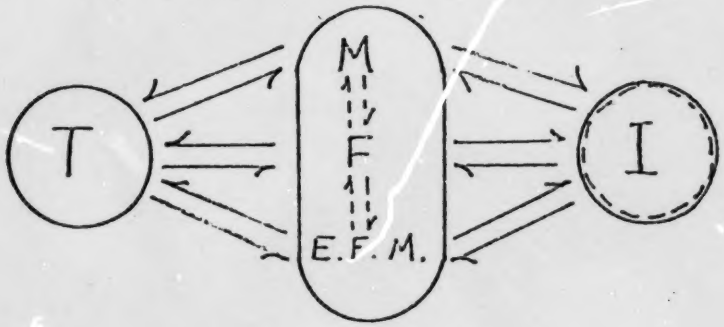
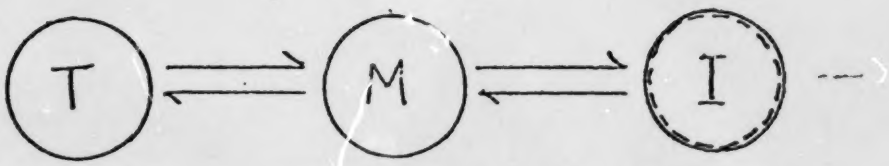
FIGURE 1: STRUCTURE OF INTERVENTIONS

1. Study Group - Family Oriented



2. Comparison Group A - Parent Centered



3. Comparison Group B - Advocacy

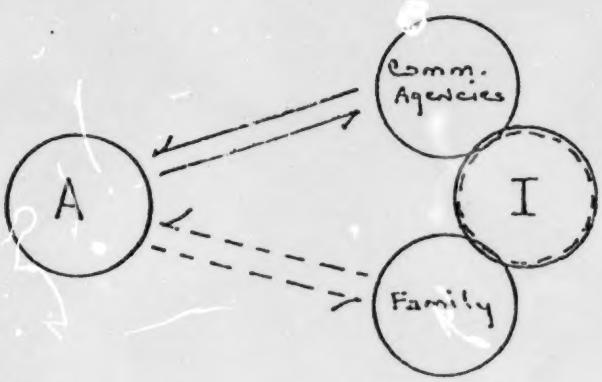
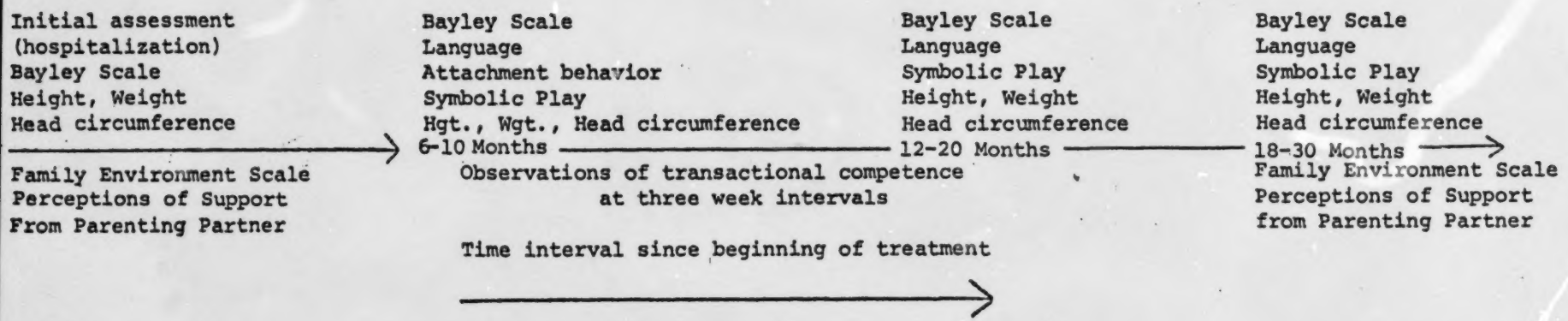


Table 1 Outline of Outcome Assessment



11

12

Slide 3

N = 32

FAMILY CHARACTERISTICS

NUCLEAR FAMILY		47%
FUNCTIONAL NUCLEAR		19%
EXTENDED FAMILY		25%
MOTHER ALONE		9%
WELFARE		65%
FAMILY SIZE	1st BORN	21%
	2nd	40%
	3rd	18%
	4th	18%
	5th	0
	6th	0
	7th	3%

Slide 4

N = 13

GROWTH PARAMETERS

	WEIGHT	HEIGHT	HEAD CIRCUMFERENCE
BIRTH	49 %ile	36 %ile	-
INTAKE ($\bar{X}$ AGE = 6.7 MONTHS)	5 %ile	7 %ile	5 %ile
12 MONTHS	21 %ile	20 %ile	48 %ile

Slide 5

N = 13

BAYLEY MENTAL DEVELOPMENT INDEX

MEAN MDI at OUTSET	98
MEAN MDI at 12 MONTH FOLLOW-UP	108

Slide 6

N = 13

STRANGE SITUATION CLASSIFICATIONS

CLASSIFICATION	DESCRIPTOR	CLASSIFICATION FROM REUNION EPISODES 5 AND 8
A	"AVOIDANT"	14%
B	"SECURE"	86%
C	"AMBIVALENT"	0